

CASE REPORT

THE MATERNAL INFANT DYADIC RELATIONSHIP – LOOKING BEYOND POSTPARTUM DEPRESSION

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Abstract

Objective: Postpartum mental illness arises from a culmination of factors at the time of the motherhood transition, and bears impact on maternal wellbeing, as well as the infant. Whilst traditional psychiatric approach focuses primarily on symptomatology, diagnostic assessment, and treatment aimed largely at symptoms relief, the infant’s wellbeing and development is of key concern. And thus follows the need to address the space between mother and infant – the dyadic experience. Understanding the world of the infant, the nature of mother-infant bonding, and possible disorders allows us to care better for mothers with perinatal mental illness. **Methods:** Literature review of the evidence and possible approaches to addressing the mother-infant relational disorder will be discussed based on case reports. In particular, the Watch Wait and Wonder technique, an infant/child-led psychotherapy will be demonstrated with case studies. **Results:** The case studies demonstrate important themes of mother-infant bonding difficulties common to mothers with postpartum mental illness. Therapy specifically addressing these issues can enable mothers to process feelings of ambivalence and conflicts that hamper the development of the dyadic relationship. **Conclusion:** The maternal-infant dyadic relationship is a key focus in postpartum mental illness, and mental healthcare for postpartum depression and other illness should consider interventions as needed. *ASEAN Journal of Psychiatry, Vol. 14 (2): July – December 2013: XX XX.*

Keywords: Postpartum Depressions, Mother-Infant Bonding Disorders, Mother-Infant Dyad, Watch Wait and Wonder

Introduction

The transition to motherhood has been described as a developmental crisis akin to adolescence, with enormous changes in all aspects – physical, psychological, interpersonal and social. The mother becomes increasingly attached to the fetus, withdrawing from her usual circle, and developing an intense dyadic connection to her baby. However, she must also then make the

shift to recognizing the infant as separate, and preparing to launch her from her womb. Towards term, there is a burst of energy as the mother prepares to deliver – the nesting experience, something natural but not uncommonly misconstrued as hypomania. Healthy mums enter a state of maternal reverie, coined by Winnicott [1] – she is enthralled and absorbed in contentment with her pregnancy and baby. For some mothers, who have had a

difficult childhood, pregnancy and the early months postpartum is a time when repressed memories invariably resurface, presenting a time for mother to either work-through their painful issues, or spiral into turmoil.

Maternal capacity for emotional connection

Much is required of mothers – providing basic needs, providing stimulation, teaching about boundaries, and discipline, and being emotionally attuned. One of the concepts is “empathic mirroring” [2, 3] – the capacity to relate to and express the emotions her baby is experiencing, and provide a reflective mirror: when baby cries in fear, the mother will soothingly reassure the baby; when baby chuckles, the mum laughs in response. Through this close dyadic connection, babies learn to know what they are feeling, and to tolerate the unpleasant feelings or enjoy the pleasurable emotions. That mothers too have their own emotive experiences then requires ego maturity to focus on baby’s inner world. Fortunately, mothers really only need to be “good enough” as Winnicott describes, rather than be “perfect” [4]. Through this, the mother provides a secure base, one that is stable and reliable, from which her baby can experience the world and grow [5].

Disorders of the motherhood transition

These capacities are disrupted in mothers with mental illness. Indeed, the nature of maternal mental illness lies in the disorder of the transitional process to motherhood. If mother is depressed, she is locked in to her own negative world, not soothing her baby, nor providing stimulation to her toddler. Research has supported this – in a sample of 72 for mother-infant pairs, mothers with depressed mood touch their infants more negatively and their speech was less well adjusted in terms of affective content, when compared to non-depressed mother, hence responding less effectively to their infants' developmental needs [6]. As a result, postpartum depression has been shown to adversely impact the emotional and cognitive functioning of the developing infant [7]. Some mothers, especially those with depression or anxiety are not able to tolerate baby’s crying or

fussiness. Others feel judged or rejected by baby, or that baby has motives (eg. “My baby is testing me”), or even that baby is not real, nor hers. Some of these may sound psychotic but these can be on a continuum of severity, and often present to a certain degree in distressed mothers.

This article examines in detail what happens when women face difficulties in the motherhood transition, the developmental needs of the infant, what happens when the bond is disrupted, what role psychiatry plays, and the gentle approach of perinatal psychiatry.

Methods

Literature review of the evidence and possible approaches to addressing the mother-infant relational disorder will be discussed, based on our case reports. The clinical presentation, underlying issues, and interventions and outcomes will be discussed using case studies. Two interventions used locally will be described - supportive counseling and the Watch Wait and Wonder technique, an infant/child-led psychotherapy.

Case Studies

The four case studies demonstrate the important themes of mother-infant bonding difficulties common to mothers with postpartum mental illness. Therapy specifically addressing these issues can enable mothers to process feelings of ambivalence and conflicts that hamper the development of the dyadic relationship.

Case study 1: Puerperal psychosis and hostility towards motherhood

Madam R, who had grown up in a rural village, was match-made to a man twelve years her senior at the young age of twenty-four. She received little emotional support from him as he was a quiet man, and suffered postnatal depression with her first daughter. Being the youngest daughter-in-law in a large extended family living in two combined public-housing flats, she had to do housework even whilst in confinement. Three years on, she had her second

child, as was expected of her role, but she became unwell at two weeks post-delivery. She presented with depressive symptoms and delusional beliefs that her neighbors were colluding with the police to remove her baby. Despite this, she cared well for her baby, and did not demonstrate any behaviours of risk to her baby.

Case study 2: Long-term implications of untreated mother-infant relational problems

Madam C, a 30-year-old mother of two, was referred by the paediatrician, for she was struggling to cope with behavioral problems in her 6 year-old son T. She had suffered from postpartum depression with Timothy, who was delivered prematurely at 27 weeks gestation, and required hospital care for two months. She was then also caring for her daughter, who was just 13 months old, and remembered trudging to the hospital daily with toddler to deliver her expressed milk, for she had little support, not even confinement help. At one point she reached breaking point, and a state of anger and resentment, and she did not visit Timothy for a whole week. She remained withdrawn from her son for the first three years, only tending to physical needs, hardly picking up her son, and often she would retreat into playing games on the computer whilst Timothy lay in the playpen. Her mood state improved after she returned to work, and Timothy went to childcare at 3 years. Madam C felt unable to like T, for he was “a quiet baby, not active, not cute, not lovable”, and admittedly said “I dislike my son”. She did recognize that Timothy was inhibited with her, seeming eager to please her, to be compliant, yet

with others, such as the domestic helper or the other children at the childcare, he was “a bully” – biting or hitting or scratching them. She felt guilty and was disappointed with herself but could not bring herself to demonstrate affection for him.

Case study 3: Supportive counseling

Mdm S, a 41 year-old professional was referred by her general practitioner at 5 weeks following the birth of her first son. She had postnatal blues which then developed into depression, and struggled much with breastfeeding. Feeling overwhelmed and exhausted, she started to have negative thoughts of giving baby away, and became preoccupied with these thoughts in the preceding week before presentation. When seen, she was distressed, and avoided contact with baby, but yet ridden with guilt for she had wanted to be a loving and nurturing mother for this long awaited baby. She was diagnosed to suffer from Major Depression, of postpartum onset, with mother-infant bonding disorder (threatened rejection). Intervention included supportive counseling (Figure 1), case management, and pharmacotherapy with oral Clomipramine 25mg nocte for 8 weeks before tapering off. She also attended the support group intervention, and her family was engaged to support and empower her in caring for the baby gradually as she became less distressed and more confident of caring for baby on her own once more. She made good recovery, with reduction in symptom scores measured on the Edinburgh Postnatal Depression Scale (EPDS), and improvement in functioning measured on the Global Assessment of Functioning.

I) INDIVIDUAL CARE

Early phase

- *Setting the therapeutic relationship*
Establishing Rapport
Developing Therapeutic Alliance
- *Empathic Listening*
Encouraging expression of emotion and thought
Clarify thinking
Empathic mirroring and validation
Support, reassurance, encouragement
- *Problem solving*

<ul style="list-style-type: none">Exploring problems, possible solutions• <u>Psychoeducation</u> Advise about illness, and possible causative factors Counseling about treatment options Counseling about expected progress <p>Mid phase</p> <ul style="list-style-type: none">• <u>Supportive therapy in dealing with individual issues</u> eg. - Addressing the mother's self-percept eg. dealing with negative self view (borrowing from CBT) - Addressing role changes (borrowing from Interpersonal therapy) - Addressing specific issues eg. unwanted or precious pregnancy, past trauma <p>Recovery Phase</p> <ul style="list-style-type: none">• <u>Psychoeducation</u> Advise about future risks Counseling regarding long term treatment – (maintenance options discussed, if needed)• <u>Empowerment, rebuilding of self</u> Enhancing strengths, positive encouragement Instilling hope, empowering woman as mother <p>II) CARE ENGAGING HUSBAND/PARTNER</p> <ul style="list-style-type: none">• <u>Psychoeducation</u> Advise about illness, treatment options Advise about risks to self/fetus or infant• <u>Counseling to enhance support to patient</u> Addressing areas of need Facilitating understanding of illness Encouraging support• <u>Brief assessment of needs of husband/partner</u> Brief exploration of husband's/partner's coping Brief exploration of needs, and counseling on resources available
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Figure 1. Supportive Counseling In Postnatal Depression

Case study 4: Watch Wait & Wonder

Madam T, a 26 year-old early childcare teacher, and mother of 16-month-old JL sought help as she felt very tired, and overwhelmed with caring for her only daughter, with low mood and fleeting suicidal feelings. She also had difficulties with her critical in-laws, who are conflicting care approach troubled her much. Jia Ling had sleep problems with frequent awakenings, and needed soothing. Madam T's EPDS score at presentation was elevated at 19

(cut-off 13 and above), and the impaired bonding subscale of the Postpartum Bonding Questionnaire was elevated at 20 (cut-off 12 and above). She was diagnosed to suffer from Postpartum Depression (minor) with impaired bonding. One of the key issues was that Madam T, was very well-read in child development issues, and had high expectations of herself as a mother. She felt a need to nurture her child constantly, and this was evident in the Watch Wait and Wonder sessions, for Jia Ling tended to stay close to her, needing reassurance, and

was not free to explore, even though she would look curiously at the toys. The challenge in therapy was that Madam T tended to rationalize Jia Ling's behaviours and would approach issues rather intellectually. The approach in therapy was then to probe gently with a supportive stance, and encourage mother to be just "good enough" and be herself rather than constantly tending to Jia Lin's needs. Madam T made good progress, and within a month, her symptoms had resolved significantly (EPDS 12) with low dose antidepressant, and the bonding difficulties had eased (PBQ impaired bonding subscale 12).

Discussion

Maternal mental illness has been conceptualized to be arising from hostility towards the infant or motherhood role, or a fear of losing her self-identity [8]. We see this most evidently in severe postpartum illness – puerperal psychosis, as described in case study 1. Freudian theory [9] explains delusions as a projection of unconscious wishes – Madam R could not even acknowledge consciously that she wished for baby to be taken off her. Understanding the nature of her inner conflicts, therapy was focused on helping her acknowledge the strain she was experiencing, bringing to consciousness her conflicts, and working with her family to provide the support and care she so needed to make the motherhood transition. She was put on low dose antipsychotic and antidepressants for just six weeks, to treat the symptoms, and made good recovery within two months of presentation. As she did not demonstrate any thoughts or behaviours that were of concern towards the baby, it was imperative to keep her close to baby, and her family was engaged in supporting her as she cared primarily for her baby. Her husband was encouraged, to provide care and support too, which he did attempt to do, even if in a limited way.

Maternal conflicts are more clearly understood because these difficulties are expressed. With the nonverbal infant, an understanding about her developmental needs is important in our work to help distressed mothers meet them. Indeed, infancy is a critical time of 1) social development – wherein the baby learns about

forming healthy relationships, understanding social norms, and what is acceptable within the cultural context; and 2) of emotional development – wherein the baby learns to make sense of various emotions, pleasurable or painful, and to regulate her feelings in culturally appropriate ways. Herein lays the foundation for self-worth, self-confidence and self-regulation.

The neurobiology of these processes is fascinating, and has been established in research [10]. In the early years, although the neurons are more or less defined at birth, the dendrites and synapses are growing phenomenally – 15 thousand within the first year of life, and more than one thousand trillion in the second year [11]. Then, depending on early events the baby is exposed to, some connections are reinforced, whilst unused dendrites are pruned, a process described as neuroplasticity [12]. Research has shown that this wiring is related to the quality of care, of parent-infant relationship, and attachment. The first 6 months are crucial for mother-infant bonding, and it is in the first 2 preverbal years that relational influences bear greatest impact. These effects are most clearly demonstrated in children who are raised in isolation and deprivation, with brain scans showing dramatically underdeveloped white and grey matter [13]. Hence, the infant in distress can appear flat, joyless, lethargic, and sad or present with feeding or sleeping problems. Or they may self-soothe by repetitive rocking. Some may seem starved for affection, and over familiar, whilst others are aggressive because they cannot trust people as past relationships have failed them [14].

The famous still face experiment demonstrates the close maternal-infant relational influence – the infant plays happily with a mother who is warm and responsive, but as mother changes to showing no emotion on her face, the infant first tries to wave at her, or attempt to distract with interest, then arches back in progressive distress [15, 16].

Mother-infant bonding disorders

These conditions have been examined in the past decades in clinical populations [17] as well as in

a Swiss population study [18], and studies on child outcomes. More recently the concept of mother-infant relationship disorders has been explored in detail by Brockington et al, 2006 [19]. The authors recognized the limitations of current diagnostic symptoms, with the ICD-10 only addressing these problems in relation to children, whilst DSM only offered a non-specified category of Parent-Child Relational Problem, and alternatively, coding can be described under the axial diagnoses. The researchers then examined a sample of 200 women presenting to 2 tertiary perinatal units in the UK & New Zealand, using the extensive Birmingham interview to validate the Postpartum Bonding Questionnaire. From the interviews, 45% of the New Zealander mothers and 60% of the UK mothers had mother-infant relationship disorders in association with axis I disorders, and distinct categories of disorders were proposed - 1)mild mother-infant relationship disorder; 2)infant-focused anxiety; 3)pathological anger (with a range from mild to severe); 4)threatened or established rejection. The authors recommended that apart from treating the axis I disorders, there was a critical need to address bonding disorders, with interventions such as play therapy, infant psychotherapy, and baby massage.

Left untreated, long-term complications can ensue, as in case study 2, wherein Madam C, whose postpartum depression though resolved, clearly still had a significant mother-child relational problem with established rejection. This highlights the critical need to address these difficulties early.

The role of the father and the family

In dealing with the infant's developmental needs, the role of the father, and the influence of the family must not be forgotten. Studies clearly demonstrate the link between paternal psychopathology and child development [20, 21]. Stella Aquarone wrote about the "eternal triangle" in a brilliant book on Infant-Parent Psychotherapy [11], wherein each parent has their own internal representations of their own parents and these in turn influence the relationships with one another in the family, in

turn in a never-ending cycle. With extensive experience working with infants and their mothers in psychotherapy, Aquarone described a case of a father who disappeared when mother was pregnant, and mother then became enmeshed with the baby, who continued to suckle, and was dressed only in diapers even at 3yrs. Using this framework, we can understand how if a woman has had an abusive and dominant father, she may then come to accept similar behaviour in her husband, and so too then will her child have a similar internal representation of the father-figure.

Interventions that address the disordered mother-infant relationship

There are many approaches to helping these mothers. With mothers seen in the Postnatal Depression Intervention Programme at KK Women's and Children's Hospital, supportive counseling as described in case study 3, has been the mainstay, with elements borrowed from cognitive behavioral therapy, and interpersonal therapy [22], with demonstrable effectiveness [23].

Another technique demonstrated in case study 4, is Watch Wait & Wonder, an infant-led psychotherapy using undirected play. Developed by Muir [24] and based on attachment theory [25], Cohen et al [26] examined 67 mums-infant pairs, in a randomized controlled trial comparing Watch Wait and Wonder to infant-parent psychotherapy, and found it led to a greater shift towards secure attachment, and greater improvement in infant emotion regulation, and as well as a larger decrease in depressed mood. An elegantly simple technique, it looks at what is happening in the space between them, as invariably, what happens daily will appear in the session. The materials are simple – a mat, a variety of age-appropriate toys, and videotaping equipment. The mother is invited to get down on the mat and play with baby, who is allowed to lead in undirected play, with the mother following. In the discussion that follows, the mother is encouraged to wonder about her baby, and in so doing, helped to become more reflective and attune to the infant's needs. This enables the mother and child to develop a "good

enough” relationship for them, rather than what the therapist ascribes as healthy.

Our role as psychiatrists – the fine line between intervention and interference

The discipline of psychiatry helps our patients frame their problems, or give a name to their distress. However sometimes, by doing so, we fail to see beyond the label, and the danger is in keeping the depressed mother in that box. With ill mothers, the tendency is to think baby must be removed – but this only goes to reinforce within her mind that she is not fit to be a mother, and makes it harder for her to make the motherhood transition successfully. Possible alternative strategies include joint admissions to mother-and-baby units, or mother-baby day hospital [27], or intensive community intervention which was pioneered by Oates in Nottingham [28]. We have tailored the latter for our Singaporean women using a case management model [29], with key elements of supportive counseling and close collaboration with the family. Madam R, who suffered from puerperal psychosis, and whose case was described above, received this intervention, and was never separated from baby. She was also validated on the tremendous stress she felt, and reassured about her ambivalent feelings, bringing to consciousness her inner conflicts – she made excellent recovery, and after two months of intervention, was taken off medication, and remained well subsequently.

What then must be our goal? It cannot just be about treating a diagnosis or prescribing medications alone. Reflecting on the oft-seen pictures of maternal reverie, and pictures of fathers supporting mothers and their babies, our role as care-providers must then be focused on establishing the secure base which holds the mother as she works through her ambivalent feelings, and move towards a closer bond with her baby.

A brilliant quote by Marina Carr, the famous Irish playwright, summarizes elegantly these concepts “I don’t think the world should assume that we are all natural mothers...the idea that you sacrifice everything for your

children...leads to very destructive living and thinking....You’re meant to adore your children at all times, and you’re not meant to have a bad thought about them....It’s like your life is not valid except in fulfilling this child’s needs. What about all your needs, your desires, your wants, your problems? They’re going to come out anyway, so it’s better they’re acknowledged straight off. Having said that...children have to be protected...to be loved ...The relationship between parent and child is so difficult and so complex. There’s every emotion there. We mostly only acknowledge the good ones. If we were allowed to talk about the other ones, maybe it would alleviate them in some way”

Conclusion

The maternal-infant dyadic relationship is a key focus in postpartum mental illness, and mental healthcare for postpartum depression and other illness should consider interventions as needed. For only then, will we have cared well for our mothers, and enabled them to make the motherhood transition.

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